Steven L. Beshear
Governor

PUBLIC PROTECTION CABINET
Department of Insurance
Agent Licensing Division
P.O. Box 517
Frankfort, KY 40602-0517
(800) 595-6053
(502) 564-6004
KOIAgentLicensingMail@ky.gov
http://insurance.ky.gov

Robert D. Vance
Secretary

Sharon P. Clark
Commissioner

DATE: February 27, 2009

TO: All Licensed Insurers Writing Long-Term Care Insurance
All Resident Insurance Producers Licensed to Sell, Solicit or Negotiate Long-Term Care Insurance
All Continuing Education Providers holding classes relative Long-Term Care Insurance

FROM: Treva W. Donnell, Director
Agent Licensing Division

RE: Producer Training – Policies Issued Under Qualified State Long-Term Care Insurance Partnership ("Qualified Partnership")

The Deficit Reduction Act (DRA) of 2005, Pub. L. 109-171 ("the DRA") allows for the expansion of Qualified Partnerships. The DRA, KRS 205.619, and KRS 304.14-640-644 require that any producer, who sells, solicits or negotiates "a policy under a Partnership receives training and demonstrates an understanding of Partnership policies and their relationship to public and private coverage to long-term care."

Accordingly, a producer with a line of authority of life or health currently authorized or who becomes authorized in the future to sell, solicit or negotiate policies issued under Kentucky's Long-Term Care Insurance Partnership Program shall complete a one time 8-hour initial training course prior to selling, soliciting or negotiating a long-term care partnership policy. Insurers offering long-term care partnership policies shall obtain verification that producers receive such training, maintain records subject to the state's record retention requirement, and make that verification available to the Insurance Commissioner upon request.

Further, each Insurer shall monitor and maintain proof that Producers receive ongoing training requirement of no less than 4-hours. The training shall cover the following topics: long-term care insurance, long-term care services, Qualified Partnerships, and the relationship between Qualified Partnerships and other public and private coverage of long-term care. Producers shall complete the ongoing training biennially according to their CE/Licensing Renewal Cycle.

NOTE: Continuing education credit will be awarded to resident licensees completing courses that have been filed and approved with this office. Further, Kentucky will reciprocate with other states where the licensee has satisfied these training requirements; therefore, training received in any state shall be deemed to satisfy the training requirements in Kentucky.

KENTUCKY DEPARTMENT OF INSURANCE
8-HOUR TRAINING OUTLINE FOR PRODUCERS
LONG TERM CARE INSURANCE, INCLUDING PARTNERSHIP

I. Long term care generally

A. Define long term care and describe when is it needed and who needs it
B. Services: skilled, personal, maintenance
C. Providers: professionals through and including informal caregivers
D. Changes and improvements in long term care services and providers

II. Alternative funding sources for long term care services

A. Private
    1. Personal and family funds/assets
    2. Other types of insurance
    3. Other
    4. Pros and cons of this type of funding (limitations)

B. Public
    1. Medicare
    2. Medicaid
    3. Other
    4. Pros and cons of this type of funding (limitations)

III. Medicaid

A. Overview: eligibility, residency, income, assets, spend down, estate recovery
B. Available long term care services and supports
C. Costs of long term care services and supports
D. Impact of partnership policies on Medicaid eligibility and estate recovery
E. Disclosure: use of partnership policy does not guarantee eligibility for Medicaid or that the benefits packages under public and private long term care insurance will be identical

IV. Long term care insurance product

A. Policy features/options/premiums and related factors impacting
B. Federally tax qualified versus non-tax-qualified long term care policies: include tax consequences of this choice
C. Effect of inflation and importance of inflation protection in a long term care policy

V. The Long Term Care Insurance Partnership

A. Describe the program, the partners, and goals
B. Four pilot partnership states – CA, CT, IN, NY
C. Changes in federal law affecting availability of partnership programs
    1. Omnibus Budget Reconciliation Act 1993 – application of estate recovery for costs of medical assistance provided unless disregard for recovery had been approved as of May 14, 1993
    2. Deficit Reduction Act of 2005 – allowing protection of assets to extent of long term care qualified partnership policy benefits spent on long term care services – qualified partnership

D. Policy features – partnership qualified
    1. Issued after state plan effective date
    2. Federally tax-qualified

3. Insured must be resident of state sponsoring partnership program when coverage is first effective
4. Consumer protection provisions – from NAIC model long term care act and regulation
5. Inflation protection – age specific at purchase

E. Related procedures
1. Exchanges
2. Coverage changes and possible effect on partnership qualified status of policy
3. Reciprocity
4. Uniformity
5. State filing of partnership qualified policies
6. Disclosure of partnership qualified nature of policy by insurer
7. Reports by insurers required to be made to Health and Human Services Secretary
8. Agent training requirements

VI. Consumer suitability standards and guidelines

A. Standards for marketing
1. Disclosures and outline of coverage
2. Comparisons
3. Unfair practices
4. Excessive insurance
5. Agent training and auditable procedures
6. Written notice of state senior program: address and phone number
7. Special requirements for marketing to associations
8. Shoppers Guide requirement

B. Suitability
1. Standards and training
2. Factors
   a. Ability to pay and other financial information
   b. Goals or needs
   c. Advantages and disadvantages
   d. Values, benefits, costs of existing insurance compared to recommended or replacement insurance
3. Personal Worksheet and Things You Should Know forms
4. Suitability letter

5. Reporting to Superintendent: applicants, declinations, etc.

<u>Appendix of Federal and State Laws and Regulations</u>

Federal, State laws and regulations, and the relationship of the long-term care insurance partnership program to other public and private long term care insurance coverage, including Medicaid.

- **Social Security Act as amended by the Deficit Reduction Act of 2005**
  - 42 U.S.C. 1902(r) – disregard of long term care policy benefits paid for qualified long term care services for purposes of Medicaid eligibility
  - 42 U.S.C. 1917(b)(1)(C)(ii) – exemption of long term care benefits from estate recovery if state plan amendment provides for qualified state insurance partnership
  - 42 U.S.C. 1917(b)(1)(C)(iii) – qualified partnership defined
  - 42 U.S.C. 1396p – liens, adjustments and recoveries, and transfers of assets

- **Internal Revenue Code (26 U.S.C. 7702B) - definition of qualified long term care policy**

- **Kentucky Insurance Department Statutes and Regulations:**
  - KRS 304.14-642– Qualified long term care insurance private program to be established by Commissioner of Insurance and Medicaid program to be established by Commissioner of Medicaid.
  - KRS 304.14-600 – 304.14-625 – Long Term Care Insurance
  - KRS 304.14-640 – 304.14-644 – Long Term Care Partnership Program
    - 806 KAR 17:081 – Long Term Care Insurance
    - 806 KAR 17:083 – Kentucky Long Term Care Partnership Insurance Program
    - 806 KAR 9:220 – Continuing Education and Training

- **Kentucky Medicaid Laws and Regulations:**
  - KRS 194A.030(2) is a statute which tabs the Department for Medicaid Services (DMS) as the single state agency authorized to administer the Medicaid program in Kentucky.
  - 907 KAR 1:585 (Estate Recovery)
  - 907 KAR 1:645 (Resource Standards for Medicaid)
  - 907 KAR 1:650 (Trust and Transferred Resource Requirements for Medicaid)
  - 907 KAR 1:655 (Spousal Impoverishment and Nursing Facility Requirements for Medicaid)
  - Medicaid Plan amendment to permit establishment of Kentucky Long-Term Care Partnership Insurance Program
  - KRS 205.8453(1) which charges DMS with control recipient fraud and abuse
  - KRS 205.8455 which sanctions the Medicaid recipient utilization review committee and delineates the committee's responsibilities as well as actions which can be taken against a recipient who commits fraud
  - KRS 205.8463 which outlines fraudulent acts (Medicaid recipient fraud) and penalties
    KRS 205.8471 which authorizes KY to place a lien on the property of a recipient found to have defrauded the Medicaid program.

NOTE: ***This outline is not all inclusive and is not intended nor shall it be construed as legal advice.***

FORM KYF-01
(9/2008)

Department Use Only
Date:______________
Amount:______________
Check #______________
Posted by:______________

AGENT LICENSING DIVISION

EDUCATION SECTION

P.O. Box 517 - Frankfort, KY 40602-0517
1-800-595-6053 (502) 564-6004
http://doi.ppr.ky.gov/kentucky/

FILING FEE SUBMISSION FORM

This form **must be completed** and sent with fees payable to the Kentucky State Treasurer, in order for courses and/or instructors to be eligible for review. A duplicate of this completed form **must** be attached to form CE/PL-100 with course material, or CE/PL-200 and mailed to Prometric, Attn: Kentucky CE, 1360 Energy Park Dr., St. Paul, MN 55108-5252.

DATE MATERIAL SUBMITTED TO PROMETRIC______________________________

PROVIDER NAME______________________________

KY PROVIDER # PR__________ PROMETRIC PROVIDER #S__________ PHONE #______________

CONTACT PERSON______________________________ E-MAIL______________________

FILING FEES ATTACHED TO REQUEST REVIEW OF THE FOLLOWING COURSES:

INDICATE TITLE OF COURSE(S): | COURSE TYPE:

(1)______________________________ ☐ CE ☐ PL
(2)______________________________ ☐ CE ☐ PL
(3)______________________________ ☐ CE ☐ PL
(4)______________________________ ☐ CE ☐ PL
(5)______________________________ ☐ CE ☐ PL

CE=CONTINUING EDUCATION; PL=PRE-LICENSING (FEE REQUIRED FOR EACH COURSE TYPE)

FILING FEES ATTACHED FOR REVIEW OF THE FOLLOWING INSTRUCTORS:

INSTRUCTOR NAME	SS#	COURSE TYPE	INSTRUCTOR NAME	SS#	COURSE TYPE
1.		☐CE ☐PL	5.		☐CE ☐PL
2.		☐CE ☐PL	6.		☐CE ☐PL
3.		☐CE ☐PL	7.		☐CE ☐PL
4.		☐CE ☐PL	8.		☐CE ☐PL

CONTINUING EDUCATION FILING FEES:

Each new course - $10.00
Each new instructor - $5.00

PRE-LICENSING FILING FEES

Each new course - $50.00
Each new instructor - $5.00

Fees must be made payable to the Kentucky State Treasurer, and sent to the Kentucky Department of Insurance, Agent Licensing Division, P.O. Box 517, Frankfort, KY 40601, with this form completed in full.

CE/PL-100 with course material and/or CE/PL-200 with Instructor information must be mailed to Prometric, Attn: KY Submissions, 1360 Energy Park Dr., St. Paul, MN 55108, with a copy of this form showing fees are paid.

You will receive an invoice from Prometric for qualifying courses in the amount of $5.00 per credit hour awarded. Payments must be payable to: Kentucky State Treasurer Mail to: Kentucky Department of Insurance, Agent Licensing Division, PO Box 517, Frankfort, KY 40602. Copy of Prometric's invoice must be included to ensure proper credit.

FOR PROVIDER USE:

ENCLOSED FIND CHECK #______________________ (PAYABLE TO KENTUCKY STATE TREASURER)

IN THE AMOUNT OF $____________, ISSUE DATE ____________ SIGNED BY ______________________

CE/PL-100 (9-2008)

Kentucky Department of Insurance
Continuing Education/Pre-Licensing Program
Course Approval Application

☐ **Continuing Education Course**

☐ **Pre-Licensing Course**

PLEASE PRINT OR TYPE. PHOTOCOPY AS NEEDED.

Provider Name	Provider Number
Course Title (maximum 40 characters)	Course Number (Leave Blank)

Course Type:

☐ Self-Study
☐ Classroom
☐ Workshop/Seminar
☐ Correspondence Towards Designation
☐ Professional Association
☐ Video/Audio
☐ Teleconference
☐ Computer Based Training (Classroom)
☐ Computer Based Training (Correspondence)

For classroom only, how many contact hours will students be required to attend class to receive credit?

____

How will classroom attendance be verified? *(check all that apply)*
☐ Periodic Roll Call or Attendee Audit
☐ Sign-in/out Sheet and Door Monitor
☐ Attendance Ticket and Door Monitor
Other ______________________________

Do you require an examination for credit?
☐ Yes
☐ No

Provide a summary description of the content and scope of the course below *(minimum 50 words)*:

____
____
____

For classroom courses: Attach a comprehensive course outline or syllabus. Annotate the outline indicating for each section the number of minutes of instruction that will be offered. Attach a copy of the final examination and exam plan, if applicable.

Course Concentration Requested:
Please check all that apply. (Ethics courses must be filed as separate course for Ethics credit to be granted.)

_____ Life
_____ Variable Life/Variable Annuity
_____ Health
_____ Property
_____ Casualty
_____ Personal Lines
_____ General Insurance Principles
_____ Life Settlement
_____ **Ethics (Must be filed as separate course)**

Has this course been previously approved by Prometric in another state? ☐ Yes ☐ No

If yes, provide Prometric-issued course number.

I certify that the information on this form and all other supporting documentation accurately represents the course of instruction that will be offered. I agree to conduct this course in accordance with all applicable policies and program requirements established by the Kentucky Department of Insurance.

Print/Type Name of Provider Representative	Signature	Date

Return this original completed form with course outline and timeframe, and/or course materials to:
Prometric, 1260 Energy Lane, St. Paul, MN 55108

Send a copy of this form (no course attachments) with course filing fees ($10.00 per course) and form KYF-01 to:
Kentucky Department of Insurance, P. O. Box 517, Frankfort, KY 40602-0517

CE/PL-200 (9-2008)

Kentucky Department of Insurance
Continuing Education/Pre-Licensing Program
Instructor Approval Application

☐ **Continuing Education Instructor**

☐ **Pre-Licensing Instructor**

PROVIDER INFORMATION

Provider Name	Provider Number

I certify that the information on this form is true and correct to the best of my knowledge. It accurately represents at least the minimum qualifications required to be met by the individual named on this form as an instructor. Further, the individual named as an instructor has been approved by this Provider.

_______________ Print/Type Name of Provider Representative

_______________ Signature

_______________ Date

_______________ Title

INSTRUCTOR INFORMATION

Instructor Last Name	First Name	Middle Name	Instructor Number (Leave Blank)

Have you been known by any other names? ☐ Yes ☐ No
If yes, list names:

Social Security Number
- -

Home Street Address

City	State	Zip Code

Business Phone
( ) ext.

List professional designations, insurance license (type, date, state):

I have specialized experience in the following subject matter:

Subject Matter	Years Experience	Designated Degree

I certify that the information on this form is true and correct to the best of my knowledge and the information accurately represents my qualifications to teach insurance courses. I understand the information on this form is subject to verification through the audit process. I agree to abide by all Kentucky statutes, regulations, and program requirements regarding insurance and insurance continuing education and pre-licensing education.

_______________ Print/Type Name of Instructor

_______________ Signature

_______________ Date

PLEASE PRINT OR TYPE. PHOTOCOPY AS NEEDED.

Return this original completed form with any attachments to:
Prometric, 1260 Energy Lane, St. Paul, MN 55108

Send a copy of this form (no attachments) with instructor filing fees ($5.00 pre-licensing, $5.00 continuing education) and form KYF-01 to: Kentucky Department of Insurance, P. O. Box 517, Frankfort, KY 40602-0517

KENTUCKY'S BASIC LONG TERM CARE ELIGIBILITY CRITERIA RELATING TO:

Resources
Resource Assessment
Look Back Period
Estate Recovery
Long Term Care Partnership Insurance

DISCLAIMER: The purpose of this document is to provide a general overview of eligibility for Medicaid Long Term Care (LTC) in Kentucky. It is intended to serve as a prerequisite to training required for insurance producers who sell, solicit or negotiate LTC Partnership insurance policies as part of the LTC Partnership in Kentucky.

The document is not to be used to determine eligibility for Medicaid LTC services. Determining eligibility for Medicaid is the responsibility of the Kentucky Department of Community Based Services (DCBS), Division of Family Support. **All Medicaid eligibility determinations shall be made only by local DCBS offices. Producers should refer consumers to their local DCBS office for assistance with Medicaid eligibility determinations.**

The information in this document relates primarily to the rules to qualify for Medicaid LTC and the interface with the LTC Partnership program. This document includes Medicaid eligibility rules and dollar limits that are correct at the time of the example. These rules and the dollar amounts change periodically.

Revised 2/27/09

TABLE OF CONTENTS

RESOURCES

OVERVIEW OF RESOURCES

Resources are generally defined as those assets an individual or couple own and/or can convert to cash. Resources may be available money, real property, personal property or other assets and may have a lien or loan attached. They may include homestead, and the cash surrender value of life insurance policies the individual has at the time of application for Medicaid. Savings, checking, stock accounts, retirement accounts, and vehicles are also examples of resources that are reviewed. Some resources may be countable and some may be excluded depending on the ownership or usage. Those issues are clarified during the application process. Although a resource may not be considered as available to the individual at application or may meet one of the exclusion criteria, it may still be subject to the Estate Recovery efforts.

RESOURCE LIMITS

An institutionalized individual's current resource limit is $2,000.

The community spouse's allowable resources are established at the resource assessment.

RESOURCE ASSESSMENT

A resource assessment determines the amount of a couples assets which can be protected for the use and benefit of the community spouse. The couples' total assets are added together and compared to the resource allowance minimum and maximum limits in place at the time of assessment. The amount that can be protected for the community spouse is adjusted each January. For current resource limits: http://manuals.chfs.ky.gov/dcbs_manuals/DFS/voliva/volivams1750.doc.

A couple or their representative can request a resource assessment when the individual is institutionalized. Once an assessment is completed it is valid unless it is discovered that all resources were not disclosed or the institutionalized spouse leaves long term care. The assessment requires the disclosure of all resources of the institutionalized spouse and community spouse. Once the resources are identified and the determination regarding countable versus excluded resources is made, the countable resources are totaled and each spouse is assigned ½. If that ½ is not greater than the community spouses' resource maximum for that year, that figure becomes the amount the community spouse can keep. Any amount over the maximum is added to the institutionalized spouse's portion and must be spent down before Medicaid eligibility can be established. If the ½ is less than the minimum, additional resources from the institutionalized spouse can be transferred to the community spouse to bring her protected portion up to the resource minimum.

The portion that is determined to be protected for the benefit of the community spouse must be placed in the name of the community spouse **only** within six months of Medicaid approval.

RESOURCE ASSESSMENT EXAMPLES

EXAMPLE 1:

Sam and Sally have the following countable resources:

Checking	$10,000
Saving	50,000
Boat	10,000
Annuity	50,000
Total	$120,000

Sam is in the nursing facility, Sally is the community spouse.

$120,000 divided by 2 equals $60,000 each which is below the maximum community spouse resource allowance.

Sally can protect $60,000 and Sam must spend down to $2,000. When a future application is made for Medicaid assistance the total countable resources must be equal to or less than $62,000.

Sally has six months from the date of application to remove Sam's name from the protected resources. Therefore, if Sally chooses to protect the boat and annuity she must have Sam's name removed from those assets.

EXAMPLE 2:

John and Mary requested a resource assessment in November 2008. They have the following countable resources:

Vacation home	$ 50,000.00
C.D	110,000.00
Life insurance policy with cash value	90,000.00
Building lot	25,000.00

Checking	30,000.00
Savings	60,000.00
Total	$365,000.00

$365,000 divided by 2 equals $182,500 each.
The maximum allowable in 2008 for the community spouse to protect was $104,400.

$182,500 minus $104,400 equals $78,100.

$78,100 must be added to the institutionalized spouse's share of $182,500 which results in his countable resource of $260,600. The institutionalized spouse must spend this down to $2,000 prior to Medicaid eligibility.

Therefore when a reapplication is made the joint countable resources must not exceed $106,400, the amount protected for the community spouse $104,400 and the $2,000 allowable for the institutionalized spouse.

EXAMPLE 3:

Tara and Cliff have the following countable resources during the resource assessment January 3, 2009:

CD	$20,000
Checking	$10,000
Total	$30,000

$30,000 divided by 2 equals $15,000 each. However, the community spouse minimum for 2009 is $21,912. Therefore the community spouse can protect $21,912. The joint resources at the time of reapplication must be equal to or less than $23,912 (the community spouses protected amount and the institutionalized spouses $2,000). In this example only $6,088 must be spent down to obtain eligibility.

NOTE: All dollars spent after the resource assessment must be accounted for at the new application.

LOOK BACK PERIOD AND PENALTIES

Federal law requires that Medicaid eligibility workers determine that assets were not disposed of for less than fair market value in order to gain Medicaid eligibility. The Deficit Reduction Act (DRA) of 2006 strengthened the language requiring that all transfers of resources shall be presumed to be for the purpose of establishing Medicaid eligibility unless the applicant could prove otherwise. The DRA also required that this investigation cover the previous 60 months from application. To accomplish this, the application date becomes the base line date (starting point) and all transfers in the previous 60 months are investigated. Goods and/or services for fair market value must be received for any transfer that occurs during this time period. For example, $10,000 given to a daughter in the 32nd month from the baseline date would be investigated. If the applicant could not demonstrate goods and/or services received for this amount, then this would be considered a prohibited transfer of resource and would be subject to a penalty period.

All resources disposed of during the "look back period" for less than fair market value are added and the total amount is used to determine an ineligibility period. The ineligibility period is based on the average daily cost of care and that factor is revised annually. The ineligibility period begins on either the date of transfer or the date the client would be otherwise eligible (had the transfer not occurred) – whichever date occurs last.

The following is an example of calculating a transfer of resource ineligibility period for Long Term Care Medicaid benefits:

A Long Term Care application was taken on August 1, 2008. There were multiple transfers that occurred prior to the application.

$4,000 was given away on 3/1/2006
$2,000 was given away on 5/15/2006
$2,000 was given away on 7/19/2006

The eligibility worker would add all transfers together, in this situation, the total is $8,000.

The worker would then determine the ineligibility period by dividing the total amount of the transfer by the current transfer of resource factor.
$8,000 divided by $156.14 (2008 factor) = 51.24 days, rounded down would be 51 days of ineligibility.

The ineligibility period would begin on the date of application, August 1, 2008. The ineligibility period is for 51 days. On the 52nd day, the applicant can reapply and if all other eligibility criteria are met, the applicant would be eligible.

ESTATE RECOVERY

Medicaid has the authority to seek recovery from the estate of a deceased Medicaid recipient in order to be reimbursed up to an amount equal to the total medical assistance paid for long term care benefits.

An estate is subject to estate recovery if the individual is at least 55 years of age AND if at anytime the individual received medical assistance for any of the following:

A. Nursing Facility (NF), not including institutionalized Hospice;
B. Intermediate Care Facility (ICF);
C. Mental Retardation/Developmentally Disabled (MR/DD) services;
D. Long term care (LTC) services provided by a waiver.

The estates of individuals under 55 years of age are also subject to estate recovery if the individual has been receiving Medicaid for NF, ICF/MR/DD or LTC waiver services for a total of six consecutive months or more at the time of death.

NOTE: Resources that were excluded during the application process may still be subject to estate recovery.

EXEMPTION AND LIMITATIONS

Estate Recovery shall not be made from the estate if the estate representative can verify that:

A. There is a surviving spouse
B. There is a surviving minor child (under 21) or disabled child
C. The estate is valued at less than $10,000
D. Recovery would create a hardship for a surviving family member. This type of exception would require a request in writing with supporting documentation.

LONG TERM CARE PARTNERSHIP INSURANCE

A qualified Long Term Care (LTC) Partnership Insurance policy will allow for an asset disregard at the time of the Medicaid application. The disregard is a one dollar ($1) increase in protected assets for every one dollar ($1) paid by the insurance policy at the time of application. Any assets protected at the Medicaid application, shall also be protected from estate recovery.

At the time of application an individual with a qualified LTC partnership policy must produce documentation of the dollar amount paid by the insurance as a direct reimbursement of LTC expenses, as well as benefits paid on a per diem or other periodic basis, for periods during which the individual received LTC services. It is not required that the partnership policy funds be fully exhausted. However, the resource protection is based on the amount actually paid at the time of application.

The applicant must identify the assets they wish to protect as a result of the LTC Partnership payments. The applicant **cannot** change the selection after Medicaid approval. The eligibility worker will then disregard the assets chosen when determining Medicaid eligibility and those assets will also be protected from estate recovery.

The applicant may wish to apply their LTC Partnership insurance protection to an asset that was excluded in the eligibility determination process. They may choose to apply their protection to that asset in order to insure protection from estate recovery.

> NOTE: Applicants without a community spouse or a minor dependent child in the home with home equity greater than $500,000 (this cap is subject to change) are technically ineligible for Medicaid. Due to this technical ineligibility, LTC Partnership insurance cannot apply in this situation.

EXAMPLES OF THE BENEFIT OF LTC PARTNERSHIP INSURANCE

If an applicant has purchased a qualified LTC partnership insurance policy and that policy paid out $100,000 as of the month of application for Medicaid, that applicant could protect an additional $100,000 of assets.

EXAMPLE 1:

Bob, a single individual, has been in the nursing facility for three years. He has homestead property valued at $85,000, and a CD valued at $20,000. On the date of his application, his LTC Partnership policy has paid out $103,000. He can protect $103,000 of resources. He is allowed to have $2,000 in resources; therefore, he can gain eligibility and protect his homestead property and CD from estate recovery.

In order to understand how LTC Partnership insurance can affect applicants with a community spouse, below are the original examples we listed in the resource assessment section. In each example, we will consider that the LTC partnership insurance has paid $50,000 benefits as of the month of application for Medicaid.

EXAMPLE 1:

Sam and Sally have the following countable resources:

Checking	$10,000
Saving	50,000
Boat	10,000
Annuity	50,000
Total	$120,000

Sam is in the nursing facility, Sally is the community spouse.

$120,000 divided by 2 equals $60,000 each which is below the maximum community spouse resource allowance.

Sally can protect $60,000 and Sam can apply his LTC partnership policy payout of $50,000 at the time of application.

The couple could protect up to $112,000 ($60,000 + 50,000 + 2,000). At this time, Sam is still $8,000 over resource limit.

Sam will need to determine when to make his second application based on the dollar amount he was over resource limit at the original application. He will need to take into consideration the monthly benefits from his LTC Partnership insurance policy and the amount he is paying for his cost of care, reducing his resources. For example, if Sam's LTC Partnership policy is paying $4,000 per month to the facility and Sam is also paying $4,000 privately he could apply the following month.

EXAMPLE 2:

John and Mary requested a resource assessment in November 2008. They have the following countable resources:

Vacation home	$ 50,000.00
C.D	110,000.00
Life insurance policy with cash value	90,000.00
Building lot	25,000.00
Checking	30,000.00
Savings	60,000.00
Total	$365,000.00

$365,000 divided by 2 equals $182,500 each.
The maximum allowable in 2008 for the community spouse to protect was $104,400.

$182,500 minus $104,400 equals $78,100.

$78,100 must be added to the institutionalized spouse's share of $182,500 which results in his countable resource of $260,600. The LTC Partnership policy has paid out $50,000, he is only over the resource limit by $208,600.

The community spouse's protected assets remain the same as long as the institutionalization remains unchanged. John needs to determine the appropriate time to reapply based on the monthly benefit of his LTC Partnership insurance policy and the rate at which his cost of care is reducing his resources.

EXAMPLE 3:

Tara and Cliff have the following countable resources during the resource assessment January 3, 2009:

CD	$20,000
Checking	$10,000
Total	$30,000

$30,000 divided by 2 equals $15,000 each. However, the community spouse minimum for 2009 is $21,912. Therefore the community spouse can protect $21,912. The joint resources at the time of reapplication must be equal to or less than $23,912 (the community spouses protected amount and the institutionalized spouses $2,000). In this example, since Cliff's LTC Partnership policy has spent more than the couple's countable resources, all resources can be protected and Cliff is financially eligible.

NOTE: All dollars spent after the resource assessment must be accounted for at the new application.